Healthy Kids Now!
HEALTHCARE FOR WASHINGTON'S KIDS

Person helping client with application:

Organization: Telephone: ( )

Washington State Department of Social & Health Services

Application For Children's Medical Benefits

This application is for medical coverage only for children and teens under 19. A parent, guardian, outreach worker, friend or teen applying for him/her self may fill out the application. **We will send the person listed in box 1 all follow-up information.** If you have questions or would like help filling out this form, just call 1-877-543-7669. We'll be happy to help you!

PLEASE PRINT **(List parent, guardian or contact person who will receive follow-up information.)**

1	FIRST NAME	MIDDLE INITIAL	LAST NAME		
2	ADDRESS WHERE YOU LIVE	STREET	CITY	STATE	ZIP CODE
3	MAILING ADDRESS (IF DIFFERENT)	STREET	CITY	STATE	ZIP CODE

4 TELEPHONE NUMBERS

HOME ( )

WORK ( )

MESSAGE ( )

5 Do you have trouble speaking, reading or writing English? Yes ☐ No ☐

Do you need materials sent to you in another language? Yes ☐ No ☐

Do you need an interpreter? (If yes, we will help you through an interpreter.) Yes ☐ No ☐

What language do you speak? _____

6 Is anyone in your home pregnant? Yes ☐ No ☐

If "yes," who? _____

Does a child under 19 have a medical condition that needs attention right away? Yes ☐ No ☐

General Information

7 List family members **living together**.
(If needed, attach a separate sheet of paper to list more family members.) **(This information will not be shared with INS)**

NAME (FIRST, MIDDLE, LAST)	RELATION TO YOU	BIRTH DATE (MO/DA/YR)	U.S. CITIZEN	IF NOT A U.S. CITIZEN, WAS YOUR **CHILD** GIVEN A DOCUMENT SHOWING HIS/HER STATUS? PLEASE ATTACH DOCUMENT	LIST DATE THIS CHILD ARRIVED IN U.S.	SOCIAL SECURITY NUMBER * = OPTIONAL	SEX M or F
A. PARENT, GUARDIAN OR SELF						*	
B. SPOUSE OR OTHER PARENT (if living in the home)						*	
C. LIST CHILDREN AND TEENS UNDER 19 YEARS OF AGE **(who want medical benefits)**			YES ☐ NO ☐	YES ☐ NO ☐			
D.			☐ ☐	☐ ☐			
E.			☐ ☐	☐ ☐			
F.			☐ ☐	☐ ☐			
G. LIST OTHER ADULTS OR CHILDREN IN THE HOME **(who do not want medical benefits)**						*	
						*	

8 Is a child under age 19 in your household disabled? Yes ☐ No ☐

If "Yes," who? _____

Expenses This information can help your children qualify.

9 Do you pay for childcare while you work or attend school? Yes ☐ No ☐ If "Yes," how much per month? $_____

Do you pay someone to take care of a disabled dependent adult while you work or attend school? Yes ☐ No ☐ If "Yes," how much per month? $_____

10 Do you pay court ordered child support for a child who is not living in your home? Yes ☐ No ☐ If "Yes," how much per month? $_____

Income

Enter GROSS pay (before taxes or expenses). Enter zero "0" if you or your spouse are unemployed or do not live in the home with these children.

11 PARENT'S EMPLOYER NAME AND PHONE

( )

12 Amount you received in the last 30 days before taxes or expenses were taken out:

$_____

How much of this income is from self employment?*

$_____

13 SPOUSE'S (OR OTHER PARENT LIVING IN THE HOME) EMPLOYER NAME AND PHONE NUMBER:

( )

14 Amount your spouse (or other parent living in the home) received in the last 30 days before taxes or expenses were taken out:

$_____

How much of this income is from self employment?*

$_____

*IF YOU OR YOUR SPOUSE (OR OTHER PARENT LIVING IN THE HOME) ARE SELF-EMPLOYED YOU MAY GET OTHER DEDUCTIONS. PLEASE CALL 1-877-KIDS-NOW FOR MORE INFORMATION OR APPLICATION ASSISTANCE.

OTHER HOUSEHOLD INCOME	AMOUNT RECEIVED IN LAST 30 DAYS	WHICH FAMILY MEMBER GETS THIS INCOME?
15 CHILD SUPPORT	$	
16 ALIMONY	$	
17 SOCIAL SECURITY PAYMENT	$	
18 UNEMPLOYMENT BENEFITS	$	
19 INTEREST FROM BANK ACCOUNT	$	
20 VETERANS BENEFITS	$	
21 LABOR & INDUSTRIES	$	
22 MILITARY ALLOTMENTS	$	
23 OTHER (Please explain)	$	

24 In the last 3 months, did any of the children you are applying for have unpaid medical bills or receive medical services NOT covered by other insurance? Yes ☐ No ☐

Health Insurance Information

Tell us about any health insurance your **children** already have.

25 A Do any of the **children** you are applying for already have health insurance? Yes ☐ No ☐

25 B If "Yes," does that health insurance cover doctor, hospital, x-ray (radiology) and laboratory services? Yes ☐ No ☐

26 A Have your **children** been covered by job-related health insurance in the last 4 months? Yes ☐ No ☐

26 B If "Yes," did it cost less than $50 per month for dependents? Yes ☐ No ☐

27 If you checked "Yes" to any of the above questions (25 a or b or 26 a or b), please list the name of the insurance company or employer providing health insurance for your children.

INSURANCE COMPANY OR EMPLOYER	POLICY NUMBER	POLICY HOLDER'S NAME	POLICY HOLDER'S SOCIAL SECURITY NUMBER (OPTIONAL)

Children's Race/Ethnic Background (Voluntary Information)

We ask you to voluntarily tell us your children's race or ethnic background. This information will not be used in considering your eligibility for benefits.

Caucasian ☐ Hispanic ☐ Black ☐ American Indian/Alaska Native ☐
Vietnamese/Laotian/Cambodia ☐ Other Asian or Pacific Islander ☐ Other ☐

Read Carefully Before Signing

This application is for medical benefits for children only. If anyone in your family already receives, or would like to apply for cash benefits, food assistance or other benefits, please contact your local DSHS Community Services Office (CSO).

- DSHS may ask you to prove the information you are giving them to tell if you are eligible. You can ask DSHS for help in getting proof.
- Your information may be reviewed by other state or federal agencies. This information will NOT be shared with Immigration and Naturalization Service (INS).
- By asking for and getting health care benefits, you give the state of Washington all rights to any medical support and to any third party payments for health care.
- DSHS may share your child's immunization history with the Child Profile Immunization Tracking System.

DECLARATION AND SIGNATURE
I have read and understood the information in this application. I declare, under penalty of perjury, the information I have given in this application is true, correct, and complete to the best of my knowledge.

Signature of Applicant

X _____ _____ Date

How to Submit

MAIL TO: **Dept. of Social and Health Services**
P.O. Box 45531
Olympia, WA 98599-5531

FAX TO: **(360) 664-0518**

FOR HELP: If you need help or have questions, please call **1-877-KIDS-NOW.** (1-877-543-7669)